UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

QUALAQUIN (quinine sulfate)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES TO 855-828-4992

CRITERIA:

- Minimum age requirement: 16 years old.
- Diagnosis of malaria.

AUTHORIZATION:

One 7 day course of up to 42 tablets is approved with each PA.

RE-AUTHORIZATION:

Same as initial PA.

9/22/10

https://medicaid.utah.gov/pharmacy/